The implementation of the new WHO recommendations on the management of TB in children and adolescents

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The Talk

• Purpose is to:
  ✓ share experience-based common civil society considerations

• Purpose is NOT to:
  ✓ share any advanced systematic-review on any scientific argument
  ✓ draw conclusions relevant for any one or more healthcare setting(s)

• Implementation of new recommendations: Four key components
  ✓ Bring services closer to children and families
  ✓ Scaled implementation of new diagnostic technologies
  ✓ New shorter regimen for non-severe DS-TB and TBM
  ✓ All oral DR-TB regimen for children (all ages)
BRING SERVICES CLOSER TO CHILDREN AND FAMILIES

• Currently child TB care is mostly at secondary hospitals – limited coverage at primary level healthcare settings

• Considerations:
  ✓ Is primary health (PHC) infrastructure & performance - suitable for child TB care?
  ✓ Is this affordable/ feasible for the program to scale child TB care at PHC level?
  ✓ Do programs have “ability” to adapt treatment decision algorithms for PHC setting?
  ✓ Any ongoing mechanism(s) to engage families in responsive child TB care?
  ✓ Any implementation research to address child care delivery/ quality challenges?
SCALED IMPLEMENTATION OF NEW DIAGNOSTIC TECHNOLOGIES: XPERT ULTRA ON STOOL SPECIMENS

• Methodological challenge:
  ✓ Lack of standardized protocols to prepare and test stool samples

• Effectiveness (scaled implementation in program context):
  ✓ additional diagnosis and incremental cost-effectiveness ratio

• Feasibility of scaled implementation:
  ✓ requirements: laboratory biosafety (level-2) and skilled personnel
  ✓ capital and recurrent cost – shorter and longer term perspectives
  ✓ competing allocation healthcare priorities in low resource settings

• Other considerations:
  ✓ requirements limits the prospects of decentralized testing at PHC level
  ✓ limited knowledge on health workers’ acceptability and feasibility

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NEW SHORTER REGIMENS FOR NON-SEVERE DS-TB AND TBM

• New shorter treatment regimen includes:
  ✓ Shorter 4-month (instead of current 6-month) regimen for non-severe DS-TB children
  ✓ Intensive 6-month (instead of current 12-month) regimen for TB Meningitis in children

BUT

✓ child TB care has weak integration with other programs and services
✓ diagnostic challenges continues to limit the potential benefits of better/shorter treatment
✓ pricing/ access to child friendly TB drug formulations remains a challenge for many programs
✓ need program-level evidence and advocacy on treatment & implementation outcomes of the two shorter regimen (short and medium term)
ALL ORAL DR-TB REGIMENS FOR CHILDREN (ALL AGES)

- New recommendations for MDRR/RR TB of all ages:
  - Use Bedaquiline as part of shorter or longer Bedaquiline-containing regimen
  - Use Delamanid as part of longer DR-TB treatment regimen
  - Pricing, access and formulation of drugs for all oral DR-TB (Bedaquiline and Delamanid containing) regimen
  - Linking DR-TB care and child-TB care – currently offered at different levels of hospital settings
  - Need program-level evidence and advocacy on treatment & implementation outcomes of all-oral DR-TB treatment in children (short and medium term)
CONCLUSION

• WHO updated recommendations: a step towards making child TB care simpler and cost-effective

BUT

• Implementation protocols and challenges need in-time attention of the programs and partners - for optimal gains across varied settings.

• Continued “learning-by-doing” and “sharing” for an informed scaling across countries and regions.
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THANK YOU